


45th 2104/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 KEITH ST NW CLEVELAND, TN 37311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain privacy during medical care, for three residents, (#21, #25, #27) of twenty-seven residents reviewed.</p>	F 164	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and comply with all applicable state and federal regulatory requirements.</u></p> <p>A one on one educational in-service was given to the facility podiatrist on 12/23/2011, by the Director of Nursing. The policies and procedures for infection control, privacy, and glove use were reviewed.</p> <p>All residents with orders for podiatry consults have the potential to be affected.</p> <p>Director of Nursing or Wing Manager will observe the podiatrist and his staff while in the facility to ensure infection control, privacy, and glove use policies are being observed. A list of all residents receiving foot care will be provided to the facility by the podiatrist. A staff member will be assigned to assist with bringing residents to their rooms and providing for privacy.</p> <p>The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.</p>	01/20/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 1/4/2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JAN 06 2012

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F 164	<p>Continued From page 1</p> <p>The findings included:</p> <p>Resident #21 was admitted to the facility on June 3, 2005, with diagnoses of Alzheimer's Disease, Parkinson's Disease, Osteoporosis and Hypertension.</p> <p>Observation on December 19, 2011, from 2:50 p.m. to 2:54 p.m., outside the resident's room, revealed the facility Podiatrist providing toe nail care to the resident, with the room door open, in direct view of staff and visitors in the hallway, with the privacy curtains open, and the resident's roommate (resident #25), present who was observing the procedure.</p> <p>Resident #25 was admitted to the facility on September 6, 2007, with diagnoses of Senile Dementia, Venous Insufficiency, Diabetes, and Hypertension.</p> <p>Observation on December 19, 2011, from 2:56 p.m. to 3:01 P.M., outside the resident's room, revealed the facility Podiatrist providing toe nail care to the resident, with the room door open, in direct view of staff and visitors in the hallway, with the privacy curtains open, and the resident's roommate, (resident #21) present, who was observing the procedure.</p> <p>Resident #27 was admitted to the facility on November 9, 2011, with diagnoses of Pneumonia, Traumatic Fracture of the Mandible and Humerus, and Dysphagia.</p> <p>Observation on December 19, 2011, from 3:03 p.m. to 3:07 P.M., outside the resident's room, revealed the facility Podiatrist providing foot care</p>	F 164		

JAN 06 2012

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F 164	Continued From page 2 to the resident, with the room door open, in direct view of staff and visitors in the hallway, with the privacy curtain open, and in direct view of the resident's roommate (resident #26), and two visitors who were observing the procedure. Review of the facility policy "Arm and Foot Soaks" (undated), revealed, "...screen and drape resident for maximum privacy" ... Interview with the Director of Nursing on December 19, 2011 at 3:15 p.m., in the Director of Nursing's Office confirmed the facility Podiatrist did not maintain the resident's privacy during the treatments.	F 164			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, policy reviews, and interviews, the facility failed to administer medications as ordered for two (#9 and #16) residents, and failed to complete an interim care plan for one (#17) resident, of twenty-seven residents reviewed. The findings included: Resident #9 was admitted to the facility on September 29, 2010, with diagnosis including Dementia, Anxiety, and Hypertension.	F 281	Interim care plan of resident # 17 was immediately completed after observation on 12/20/2011. All newly admitted residents who need interim care plan have the potential to be affected. All residents with physician orders written for Medications have the potential to be affected. Nursing staff will be in-serviced by the Staff Development Coordinator on care plan policy by 01/13/2011. Nursing staff will be in-serviced by the Staff Development Coordinator on the procedure for obtaining medications from the emergency box. Nurses will also be trained on obtaining medications stat from the pharmacy when not available in the emergency box. The in-service will be completed by 01/13/2011.	01/20/2012	

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F 281	<p>Continued From page 3</p> <p>Medical record review of a Physician Order dated September 20, 2011, at 5:30 p.m., revealed "...Keflex (antibiotic) 500mg (milligram) BID (twice daily)..."</p> <p>Medical record review of the Medication Administration Record dated September 2011, revealed the first dose of Keflex 500 mg was administered on September 21, 2011, at 8:00 a.m.</p> <p>Medical record review of a Physician Order dated November 3, 2011, at 3:00 p.m., revealed "...Clindamycin (antibiotic) 300mg TID (three times daily) for 10 days..."</p> <p>Medical record review of the Medication Administration Record dated November 2011, revealed the first dose of Clindamycin 300 mg was administered on November 4, 2011, at 8:00 a.m.</p> <p>Interview on December 20, 2011, at 8:18 a.m., with the East Wing Unit Manager, at the East Wing Nurses' Station, confirmed the Keflex 500 mg was not administered September 20, 2011, the Clindamycin 300 mg was not administered November 3, 2011, the antibiotics were available in the emergency box and the facility failed to administer the antibiotics in a timely manner.</p> <p>Resident #16 was readmitted to the facility on July 20, 2011, with diagnosis including Pyelonephritis, Diabetes Mellitus, and Dementia.</p> <p>Medical record review of a Physician Order dated September 8, 2011, at 2:30 p.m., revealed</p>	F 281	<p>Wing Managers will complete audits on newly ordered medications weekly X four then monthly X two. The audits will be performed to ensure newly ordered medications are began timely. The results of the audit will be turned in to the Director of Nursing.</p> <p>Nurse management will perform audits on interim care plans weekly X four weeks, then monthly X two months. The audits will be performed to ensure that interim care plans are completed timely. The results of the audits will be turned in to The Director of Nursing.</p> <p>The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.</p>		

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F 281	<p>Continued From page 4</p> <p>"...Vantin (antibiotic) 200mg BID for 10 days..."</p> <p>Medical record review of the Medication Administration Record dated September 2011, revealed the first dose of Vantin 200 mg was administered on September 10, 2011, at 8:00 a.m.</p> <p>Medical record review of a Physician Order dated September 12, 2011, at 6:30 p.m., revealed "...Azithromycin (antibiotic) 500mg daily for 7 days..."</p> <p>Medical record review of the Medication Administration Record dated September 2011, revealed the first dose of Azithromycin 500 mg was administered on September 16, 2011, at 8:00 a.m.</p> <p>Interview on December 21, 2011, at 9:00 a.m., with the East Wing Unit Manager, at the East Wing Nurses' Station, confirmed the Vantin 200 mg was not administered September 8 and 9, 2011 (five missed doses of Vantin), the Azithromycin 500 mg was not administered until September 16, 2011 (two missed doses of Azithromycin), Azithromycin was available in the back up box and the facility failed to administer the antibiotics in a timely manner.</p> <p>Medical record review revealed Resident #17 was admitted to the facility on December 13, 2011, with diagnoses which included Aftercare for Traumatic Hip Fracture, History of Falls, Muscle Weakness, Paranoid Schizophrenia, Depression, and Anticoagulant Therapy.</p>	F 281		

JAN 06 2012

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F 281	Continued From page 5 Review of Resident #17's medical record on December 20, 2011, revealed the Interim Care Plan had no information other than the residents name documented. Review of the facility's policy titled, "Resident Care Plan" (no date on policy) revealed, "An interim care plan is to be completed upon admission". Interview with the Director of Nursing (DON) on December 20, 2011, at 2:30 p.m., in the DON's office confirmed the Interim Care Plan had not been completed. Further interview with the DON confirmed it was facility policy to complete the Interim Care Plan within 24 hours following admission.	F 281		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	One on one education was given to Physician regarding signing recommendations timely. Discussed procedure for timely implementation of pharmacy recommendations. Any resident utilizing pharmacy services has the potential to be affected. The pharmacy representative will leave all pharmacy recommendations with the Director of Nursing. The Director of Nursing will contact the physician or nurse practitioner same day for review and signing. After recommendations are reviewed and signed the Director of Nursing or representative will distribute the recommendations to the Wing Managers for timely implementation. This procedure will be in place by 01/20/12.	01/20/2012

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F 329	<p>Continued From page 6</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement physician's orders timely, resulting in unnecessary medication doses for one resident (#16) of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #16 was readmitted to the facility on July 20, 2011, with diagnosis including Pyelonephritis, Dementia, and Diabetes Mellitus.</p> <p>Medical record review of a pharmacy recommendation dated November 10, 2011, revealed a recommendation by the pharmacy, to the attending physician to reduce Claritin (antihistamine) 10 mg (milligram) daily to every other day. Continued medical record review revealed no documentation the recommendation was reviewed until November 14, 2011, when the physician agreed with the recommendation.</p> <p>Medical record review of the Medication Administration Record dated November 2011, revealed the facility failed to implement the order until November 23, 2011, resulting in six unnecessary doses of Claritin 10 mg.</p>	F 329	<p>Nursing staff, physician, pharmacy representative will be in-serviced by the Staff Development Coordinator or the Director of Nursing on new Procedure for implementation of pharmacy recommendations. The in-service will be completed by 01/19/2011.</p> <p>The Director of Nursing or representative will audit the pharmacy recommendations monthly X three months to ensure timely implementation is occurring.</p> <p>The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.</p>		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

 FORM APPROVED
 OMB NO. 0938-0391

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F 329	Continued From page 7 Interview with the East Wing Unit Manager on December 21, 2011, at 9:00 a.m., in the East Wing Nurses' Station, confirmed the facility delayed implementing the physician's order resulting in six unnecessary doses of Claritin 10 mg.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sanitizing liquid was separated from the food. The findings included: Observation on December 19, 2011, at 10:00 a.m., with the Dietary Manager, revealed three small plastic buckets of sanitizing solution, one under the food preparation table stored next to a box of potatoes and box of bananas, and another two small buckets under another preparation	F 371	No Residents were affected by the cited practice. Food and Nutritional Services personnel were verbally in-serviced immediately on the fact that proper usage of sanitizing liquid is to be maintained away from food sources. The FNS Personnel identified proper locations and adjustments were implemented immediately. The sanitizing solution was removed from the shelving immediately and a placement-tracking log was implemented by the FNS Director to ensure compliance was met and maintained. No Residents were affected by the cited practice. Corrective action Explained below The FNS Director conducted verbal education immediately following the physical inspection. Compliant locations for sanitizing buckets were identified. And, physical placement of sanitation buckets was corrected. Written education began on 12/22/2011 regarding designated locations for proper storage of sanitizing buckets. Sanitation bucket placement tracking log was implemented on 12/19/11. This placement log has been made standard operating procedure. This log is signed by associates on a daily basis. The FNS Director and Registered Dietician (RD) will round weekly x four months or until substantial compliance is met and maintained	01/20/2012	

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F 371	Continued From page 8 table stored next to additional food. Interview with the Dietary Manager at the time of observation, confirmed the sanitizing buckets of solution were not to be stored next to the food.	F 371	The FNS Director working in tandem with the Registered Dietitian monitor placement of sanitation buckets every day/ all shifts. The FNS director ensures completion of "Tracking Placement of Sanitation buckets Log" on a daily basis. The FNS Director will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.	01/20/2012
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pharmaceutical services in a timely manner for two residents (#9 and #16) of twenty-seven residents reviewed.	F 425 One on one educational in-service was given to the licensed Practical Nurse on 12/20/2011 by east wing manager. The policy and procedure for obtaining medications from pharmacy timely was reviewed. Any residents with physician orders to receive medications has the potential to be affected. Nursing staff will be in-serviced by the Staff Development Coordinator on the policy and procedure for obtaining medications from the pharmacy, with special focus on ensuring medications are available timely. In-service will be completed by 01/13/2011. Nursing administration and Director of Nursing to complete Medication Administration Record audits daily X four weeks, then weekly X four weeks, and then monthly time's one month. The audits will be completed to ensure that medications were available and given as scheduled. The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.		

JAN 06 2012

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P 13/22

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F 425	<p>Continued From page 9</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on September 29, 2010, with diagnosis including Dementia, Anxiety, Hypertension and Bronchitis.</p> <p>Medical record review of a telephone order dated September 20, 2011, at 5:30 p.m., revealed "...Flonase (antiasthmatic) nasal spray 2 sprays each twice daily..." Further medical record review of the Physician Orders dated September 2011, revealed "...Atenolol 25mg daily..."</p> <p>Medical record review of the Medication Administration Record dated September 2011, revealed the resident did not receive Flonase on September 21, 2011, Atenolol (antihypertensive) 25 mg (milligram) on September 21 and 22, 2011, and "...RX (pharmacy) to deliver..."</p> <p>Medical record review of the Physician Order's dated August 2011, revealed "...Xanax (anxiety) 0.5 mg one po (per mouth) three times a day..."</p> <p>Medical record review of the Medication Administration Record dated August 2011, revealed Xanax 0.5 mg not given August 21, 2011, at 8:00 a.m., 2:00 p.m., and 8:00 p.m., and "...Xanax not refilled notified pharmacy..."</p> <p>Interview with the East Wing Nurse Manager on December 20, 2011, at 8:18 a.m., in the East Wing Nurses' Station, confirmed the Flonase and the Xanax 0.5 mg was not administered because the facility failed to obtain the medication from the pharmacy.</p>	F 425			

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F 425	Continued From page 10 Resident #16 was readmitted to the facility on July 20, 2011, with diagnosis including Pyelonephritis, Diabetes Mellitus, Dementia, and Bronchitis. Medical record review of a telephone order dated September 14, 2011, at 5:00 p.m., revealed "...Flonase nasal spray 2 sprays each nare daily..." Medical record review of the Medication Administration Record (MAR) dated September 2011, revealed the resident did not receive Flonase on September 14 and 15, 2011 resulting in two missed doses, and Nurse's Medication Notes dated September 14, 2011, at 8:00 p.m., revealed, "...Flonase unavailable at present RX to deliver later..." Interview with the East Wing Nurse Manager on December 21, 2011, at 9:00 a.m., in the East Wing Nurses' Station, confirmed the Flonase was not administered because the facility failed to obtain the medication from the pharmacy.	F 425			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	One to one educational in-service was given to the facility podiatrist on 12/23/2011, by the Director of Nursing. The policies and procedures for infection control, privacy, and glove use were reviewed. All residents with orders for podiatry consults Have the potential to be affected. Director of Nursing or Wing Manager will observe the podiatrist and his staff while in the facility to ensure infection control, privacy, and glove use policies are being observed.		01/20/2012

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F 441	<p>Continued From page 11 In the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to follow infection control protocols for three residents, (#21, #25, #27) of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Observation on December 19, 2011, from 2:50 p.m. to 2:54 p.m., on the south hallway, revealed</p>	F 441	<p>A list of all residents receiving foot care will be provided to the facility by the podiatrist. A staff member will be assigned to assist with bringing residents to their rooms and providing for privacy.</p> <p>The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.</p>		

JAN 06 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CLEVELAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 KEITH ST NW CLEVELAND, TN 37311
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F 441	<p>Continued From page 12</p> <p>the facility Podiatrist providing toe nail care to resident #21. Continued observation revealed, after completion of the procedure, the Podiatrist exited the room, disposed of soiled gloves, and soiled equipment, then donned clean gloves without washing the hands, and proceeded to administer toe nail care to resident #25 from 2:56 p.m. to 3:01 p.m. Upon completion of the procedure, the Podiatrist exited the room, disposed of soiled gloves and equipment, and proceeded to the Rehabilitation Hallway without washing the hands.</p> <p>Observation on December 19, 2011, from 3:01 to 3:07 p.m., on the rehabilitation hallway, revealed the Podiatrist donning gloves without washing the hands, and then providing toe nail care to resident #27. Upon completion of the procedure, the Podiatrist exited the resident's room, disposed of the soiled gloves and equipment, and again failed to wash the hands.</p> <p>Review of the facility policy "Hand Hygiene" revealed, "Hand washing ...when hands are visibly dirty with a proteinaceous material or are visibly soiled...Waterless Hand washing Products...if hands are not visibly soiled use...in all clinical situations other than those listed under Hand washing above..."</p> <p>Interview with the Director of Nursing, on December 19, 2011 at 3:15 p.m., in the Director of Nursing's office, confirmed hand washing was to be performed before and after all clinical care, and the Podiatrist had not followed the facility infection control policy.</p>	F 441		

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F 502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain laboratory services for two residents (#9 and #16) of twenty-seven residents reviewed.</p> <p>The findings included:</p> <p>Resident #9 was admitted to the facility on September 29, 2010, with diagnosis including Dementia, Anxiety, Hypertension, and Diarrhea.</p> <p>Medical record review of a physician's order dated November 14, 2011, revealed "...Obtain c-diff(clostridium difficile) specimen (stool) x 3..."</p> <p>Medical record review of the resident's laboratory results revealed one c-diff specimen obtained on November 16, 2011.</p> <p>Interview with the Director of Nursing (DON) on December 20, 2011, at 8:10 a.m., in the DON office, confirmed only one stool for c-diff was obtained and the facility failed to obtain two of three specimens ordered for the resident.</p> <p>Resident #16 was readmitted to the facility on July 20, 2011, with diagnosis including Pyelonephritis, Diabetes Mellitus, and Dementia.</p>	F 502	<p>A BMP (basic metabolic panel) was obtained on resident #16 on 12/20/2011 after observation. A one on one educational in-services was given to Licensed Practical Nurse on 12/20/2011 by the east wing manager. The procedure for transcribing lab orders was reviewed.</p> <p>Any resident with physician orders for labs has the potential to be affected.</p> <p>Nursing staff will be in-serviced by the Staff Development Coordinator on the policy and procedures for transcribing and obtaining labs. The in-service will be completed by 01/20/2011. Nursing administration and Director of Nursing to audit lab book weekly X four weeks, monthly X two months. Comparing lab book entries to actual lab results to ensure labs are being completed as ordered.</p> <p>The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months or until compliance are met.</p>	01/20/2012

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F 502	<p>Continued From page 14</p> <p>Medical record review of a physician's order dated September 20, 2011, revealed "...Repeat BMP (basic metabolic panel) in 1 week..." and a physician's order dated November 15, 2011, revealed "...BMP on Monday 11-21-11..."</p> <p>Medical record review of the resident's laboratory results revealed no BMP obtained on September 20, 2011, and November 21, 2011.</p> <p>Interview with the East Wing Nurse Manager on December 20, 2011, at 3:50 p.m., in the East Wing Nurses' Station, confirmed the facility failed to obtain the laboratory services for the resident.</p>	F 502			

JAN 06 2012